**Health and Community Supports Contract**
**between**
**Department of Health and Human Services**
**and**
**(County) County**

**Amendment to Calendar Year 2003 Contract**

Whereas, DHFS and (County) County's Care Management Organization (CMO) entered into and are now operating under a contract for long-term care services, which took effect January 1, 2003; and

Whereas, the contract provided at Article XI.A. that it may be modified or amended at any time by the mutual consent of DHFS and CMO;

Now, therefore, in consideration of the foregoing recitals and of the mutual promises contained herein, DHFS and CMO hereby agree as follows:

**1. Sections A., B. and F. of Article II. *CMO Functions: Enrollment and Disenrollment* are hereby amended to read as follows:**

A. Approval of Marketing/Outreach Plans and Materials
The CMO agrees to engage only in marketing/outreach activities that are pre-approved in writing, as follows:

1. *Initial Plan Approval by DHFS*
The CMO shall have a marketing/outreach plan approved in writing by DHFS by the effective date of this contract.

2. *Annual DHFS Review*
Annually, the CMO shall submit a marketing/outreach plan to DHFS and receive written approval before future contracts will take effect.

3. *DHFS Approval of Marketing Material*
The CMO shall submit to DHFS for approval all marketing/outreach materials, including mailings sent only to members, prior to disseminating the materials.

DHFS will review the marketing/outreach plan and materials as soon as possible, but within ten business days of receipt. Marketing/outreach materials are deemed approved if there is no response from DHFS within ten business days. However, problems and errors subsequently identified by DHFS, insofar as they pertain to the prohibited practices listed below, must be corrected by the CMO when they are identified.

Approval of marketing/outreach plans and materials will be reviewed by DHFS in a manner which does not unduly restrict or inhibit the CMO's marketing/outreach plans and materials, and which considers the entire content and use of the marketing/outreach materials and activities. Specific language approved by DHFS may be used again or in other media without being resubmitted for approval.

4. *CMO Operated by a County*
   For any CMO operated by a county, all marketing and outreach materials must indicate that the CMO is a county agency and the county is also operating the Resource Center.

5. *Local Long-Term Care Council Review*
   All marketing/outreach materials must be reviewed by the Local Long-Term Care Council (LLTCC) to assure materials are understandable and readable for the average consumer.

6. *Prohibited Practices*
   The following marketing/outreach practices are prohibited:
   a. Practices that are discriminatory;
   b. Practices that seek to influence enrollment in conjunction with the sale of any other insurance product;
   c. Direct and indirect cold calls, either door-to-door or telephone;
   d. Offer of material or financial gain to potential members as an inducement to enroll;
   e. Activities and materials that could mislead, confuse or defraud consumers;
   f. Materials that contain false information;
   g. Practices that are reasonably expected to have the effect of denying or discouraging enrollment; ~~and,~~
   h. Marketing/outreach activities that have not received written approval from DHFS**; and**
   **i. Activities or materials that make any assertion or statement that the CMO is endorsed by CMS, the Federal or State government, or any other entity.**

7. *Marketing/Outreach Materials and Activities*
   Marketing/outreach materials shall be distributed to all consumers eligible for the CMO in the service area. DHFS will determine what marketing/outreach materials and marketing/outreach activities are subject to the requirements of this contract.

B. Member Handbook

A member handbook shall be reviewed and approved using an internal CMO advisory body (as defined under Article III.E(2)(j), *Sensitivity to Population*, page 33[1]).

1. *Required Information*

   The handbook at a minimum will include information about:

   a. Being a member of the CMO. This information shall include the nature of membership in a Care Management Organization as compared to fee-for-service;
   b. Obtaining assistance for members with cognitive impairments to review materials about membership in the CMO;
   c. Location(s) of the CMO facility or facilities;
   d. Hours of service;
   e. Information on services in the LTC benefit package, including:
      i. List of services in the LTC benefit package;
      ii. Each member's right to select from the CMO's network of providers, and any restrictions on member rights in selecting providers;
      iii. Ability to change providers;
      iv. Any cost sharing related to these services; and,
      v. The right of each member seeking residential services to request a private room and explanation of procedures to meet this request when a private room is not immediately available;

   f. Information on Medicaid covered services not in the LTC benefit package that remain fee-for-service and procedures for obtaining these services (for members who are Medicaid beneficiaries), including:
      i. The list of these services;
      ii. How and where to obtain these services;
      iii. How transportation is provided; and,
      iv. Any cost sharing related to these services.

   g. Provider network listing which includes:
      i. Provider name (individual practitioner, or agency as appropriate);
      ii. Provider location, and telephone number;
      iii. Services furnished by the provider;
      iv. Any known provider limitations in accepting new CMO members (if a preferred provider is not accepting new members, the CMO assist the member in obtaining an alternate provider.); and,
      v. Accessibility of the provider's premises (if the member will be receiving services at the provider's premises).

[1] Cross-references listed in this amendment refer to the original 2003 Health and Community Supports Contract.

h. The right to receive services from culturally competent providers, and information about specific capacities of providers, such as languages spoken by staff, etc;
i. Information on the extent to which members may obtain services outside of the provider network;
j. Policies and procedures for advance authorization of services, and on the members' ability to obtain services necessary to achieve outcomes;
k. Policies on use of after hours services and obtaining services out of the CMO's service area;
l. Information on voluntary enrollment, voluntary disenrollment, and involuntary disenrollment;
m. Members' rights and responsibilities as defined by DHFS;
n. Information about independent advocacy services available as sources of advice, assistance and advocacy;
o. Appeal and grievance process:
    i. What constitutes an appeal, grievance, or fair hearing request;
    ii. How to file appeals, grievances and fair hearing requests, including timeframes and the member's ability to appear in person before the CMO personnel assigned to resolve appeals and grievances;
    iii. Information about the availability of assistance with the appeal and grievance process, and fair hearings;
    iv. Toll-free numbers that the member can use to register a appeal or submit a written grievance by telephone;
    v. Specific titles and telephone numbers of the CMO staff who have responsibility for the proper functioning of the process, and who have the authority to take or order corrective action;
    vi. Assurance that filing an appeal or grievance or requesting a fair hearing process will not negatively impact the way the CMO, its providers, or DHFS treat the member; and,
    vii. How to obtain services during the grievance and fair hearing processes.

p. Procedure for members to have input on changes in the CMO's policies and services;
q. Notice of right to obtain information on results of member surveys;
r. Information regarding estate recovery provisions applying to CMO membership;
s. If the CMO is operated by a county, indication that the CMO is a county agency and that the county also operates the Resource Center; and,
t. Information on the Family Care Member Outcome Interview process, including the possibility that the CMO will ask the member to participate.

2. *Annual Handbook Review*
The CMO shall have an updated member handbook approved by DHFS before the effective date of this contract.

3. *Handbook Updates*
   The CMO shall provide members periodic updates to the member handbook as needed to explain changes ~~in the above areas~~ **in Article II. B. 1, at least 30 days in advance of the effective date of the change**. Such changes must be approved by DHFS prior to distributing. Changes are considered approved if there is no response from DHFS within 10 business days. However, problems and errors subsequently identified by DHFS shall be corrected by the CMO.

4. *Notices About Provider Changes*
   Notices about changes in providers that are to be sent to members and shared with the Resource Center must be submitted to DHFS for prior approval. DHFS will respond as soon as possible, but within 30 calendar days. **Upon approval, the CMO shall provide each member written notice of the change at least 30 days before the effective date of the change.**

5. *Member Handbook Dissemination to Non-CMO Members*
   The CMO shall provide the Resource Center and Enrollment Consultant with Department approved member handbooks for the purpose of dissemination to potential CMO members.

6. *Member Handbook Dissemination to CMO Members*
   The CMO shall provide members a member handbook annually at a minimum.

***7. Prohibited Practices***
   **The member handbook cannot contain any assertion or statement that the CMO nor any of its contracted providers are endorsed by CMS, the Federal or State government, or any other entity.**

F. Enrollment/Disenrollment, and Re-Enrollment Process

1. *Monitoring by DHFS*
   The CMO shall permit DHFS to monitor enrollment and disenrollment practices of the CMO under this contract.

2. *Interactions with Other Agencies related to Eligibility and Enrollment*
   a. The CMO shall fully cooperate with other agencies and personnel with responsibilities for eligibility determination, eligibility re-determination, and enrollment in the CMO. This includes but is not limited to the resource center, economic support and the enrollment consultant. The CMO shall participate with these agencies in the development and implementation of a plan that describes how the agencies will work together to assure accurate, efficient and timely eligibility determination and re-determination and enrollment in the CMO.

b. The CMO shall jointly develop with the resource center protocols for voluntary and involuntary disenrollments, per contract specifications.
c. The CMO shall have an MOU or other written agreement with the resource center that describes the circumstances in which the CMO will provide services to an individual who is functionally eligible for the Family Care benefit but whose financial eligibility is pending, and that includes a process for the Resource Center to inform the individual that if the individual is determined not to be eligible, the individual will be liable for the cost of services provided by the CMO.

3. *Discriminatory* A*ctivities*
Enrollment continues as long as desired by the eligible member regardless of changes in life situation or condition, until the member voluntarily disenrolls, loses eligibility, or is involuntarily disenrolled according to terms of this contract. The CMO may not discriminate in enrollment and disenrollment activities between individuals on the basis of life situation, condition or need for long-term care or health care services. The CMO shall not discriminate against a member based on income, pay status, or any other factor not applied equally to all members, and not base requests for involuntary disenrollment on such grounds.

4. *Dates of Enrollment and Disenrollment*
a. The CMO shall enroll and begin serving individuals as of the effective date of enrollment on the Enrollment Request form, or the Family Care eligibility certification start date, whichever is later. Enrollment dates will not be entered for dates more than 6 calendar months in the past unless an error was made by EDS or by the ES worker. If the CMO determines that it was an ES error a copy of the original enrollment form must be submitted to DHFS for review.

b. A voluntary disenrollment shall be effective on the date indicated on the disenrollment form as effective disenrollment date, **but not later than the first day of the second month following the month in which the enrollee files the request**.

c. An involuntary disenrollment shall be effective on the date approved by DHFS as the disenrollment date**, but no later than the first day of the second month following the month in which the CMO filed the request**. In order to allow time for the member to grieve an involuntary disenrollment decision from DHFS, DHFS shall retain the disenrollment form for 14 calendar days after the member has been notified by DHFS before forwarding it to the Medicaid fiscal agent or economic support worker to process the disenrollment. If the member files a grievance of an involuntary disenrollment decision to the fair hearing process within 14 calendar days, disenrollment shall be delayed until the grievance is resolved.

d. If the member dies, the date of disenrollment shall be the date of death.

e. Loss of eligibility resulting in disenrollment **shall have effective dates as identified in i. and ii. below, but no later than the first day of the second month following a month in which the enrollee files the request**.

i. If a CMO member is planning to or has moved out of the CMO service area, the CMO shall complete a Family Care CMO disenrollment form and send copies of the form to both the Resource Center and the Economic Support Unit. The date of disenrollment shall be the date the member moved out of the service area. The member's signature is not required on the enrollment form in this circumstance.

ii. If a CMO member loses eligibility for a reason other than a move out of the service area, the last day of eligibility shall be set according to adverse action logic in CARES. The disenrollment date will be the date eligibility ends. The CMO shall continue to provide services to the member until the date of disenrollment.

5. *Re-enrollment*
In the case of voluntary disenrollment, the CMO shall allow an individual to re-enroll one time if the individual meets eligibility criteria. If the member voluntarily disenrolls for a second time, subsequent re-enrollments are at the discretion of the CMO. If the CMO chooses to consider subsequent re-enrollments, decisions shall be based on policies which do not discriminate based on cost, life situation, health status or condition. Prior to allowing individuals to re-enroll after two (2) or more voluntary disenrollments, the CMO shall have such policies approved by DHFS.

6. *Level of Care Re-determinations*
The CMO shall develop procedures to assure prompt administration of the LTCFS for members of the CMO which at a minimum shall include:
   a. The LTCFS will be conducted annually after enrollment by an individual trained and certified to administer the screen, and the member must receive an "intermediate" or "comprehensive" rating for continued enrollment in the MCO, unless the individual is eligible under the grandfathering criteria.
   b. The CMO may request a trained and certified screener to re-administer the LTCFS to re-evaluate the member's level of care rating, if the member's condition changes significantly.
   c. If the trained screener administering the LTCFS is an employee, or under direct supervision of the CMO, no Medicaid Administration reimbursement maybe claimed for administration of the screen.

7. *Accuracy of Information*
   The CMO shall not knowingly misrepresent or knowingly falsify any information on the LTCFS. The CMO shall also verify the information it obtains from or about the individual with the individual's medical, educational, and other records as appropriate to ensure its accuracy.

8. *Standards for Staff Qualifications*
   The CMO shall ensure that staff members who administer the functional screen meet all qualifications to be members in CMO interdisciplinary teams.

   In addition, individuals administering the LTCFS must pass the post test designed by the Department and shall be certified as a functional screener by the Department before being allowed to administer the functional screen on individuals.

9. *Policies and Procedures Concerning Functional Screen Quality*
   The CMO shall develop and implement Department-approved policies and procedures to ensure the accuracy and timeliness of all of the functional screens done by the CMO or CMO contractors. These policies and procedures shall include provisions for the CMO to do at least all of the following:
   a. Designate a staff member who meets all of the requirements to administer the LTCFS to be a screen lead and have this screen lead do the following:
      i. Act as the liaison between the Department and the CMO with respect to all of the issues involving the quality of the screens done by the CMO;
      ii. Attend all of the screen lead meetings held by the Department; and,
      iii. Randomly sample completed screens to make sure that they are accurate and complete.

   b. Have all of the screeners read and follow all of the instructions for the functional screen issued by the Department and all of the updates issued by the Department to these instructions;
   c. Train, mentor, and monitor new screeners;
   d. Work with the Department to maintain an accurate, complete, and up-to-date list of all of the staff members who are screeners;
   e. Consult with the Department about cases where it is proving unusually difficult for the CMO to complete an accurate screen on an individual or to interpret all or part of a completed screen;
   f. Have the screen lead and other screeners participate in all of the training on the screen that the Department requires them to participate in;
   g. Have all of the screeners complete at least once during the effective term of this contract the hypothetical case scenario exercise that the Department creates and implement any improvement projects or correction plans the Department requires to ensure the accuracy and thoroughness of the screens done by its screeners if the Department concludes, after reviewing

the results of this exercise, that there are or may be problems in these areas and communicates this conclusion to it; and,

h. Discuss with the Department what changes, if any, it might need to make in the way that it does its screening if the Department concludes, after analyzing data from screens that the CMO has done, that there are or may be problems with the way it is doing its screening and communicates this conclusion to it in the quarterly reports or in the annual report that the Department prepares on screen data and sends to the CMO or in any other way at any other time.

10. *Department Deadlines for Submission and Approval*
    The CMO and the Department shall observe the following deadlines for the submission and approval of the Care Management Organization's policies and procedures concerning the quality of the screens that it does.
    a. The (CMO) shall submit these policies and procedures to the Department no later than January 15, 2003.
    b. No later than forty (40) calendar days after the (CMO) submits these policies and procedures, the Department shall review them and shall notify the CMO whether it approves them in whole or in part. If and when the Department notifies the Resource Center that it approves them in part, it shall also notify the Resource Center of the ways in which the Resource Center needs to change them to make them comply with the requirements of this contract.
    c. In the event that the Department does notify the CMO that the CMO needs to change these policies and procedures to make them comply with the requirements of this contract, the CMO shall resubmit them with the requested changes to the Department no later than fifteen (15) calendar days after being notified by the department of the need to change them. The Department shall notify the CMO whether it approves these policies and procedures with the requested changes no later than fifteen (15) calendar days after receiving them with the requested changes.

**2. Section H. of Article III. *CMO Functions: Services* is hereby amended to read as follows:**

H. Advance Directives
The CMO shall comply with requirements of federal and state law with respect to advance directives (e.g., living wills, durable power of attorney for health care) and shall maintain written policies and procedures related to advance directives. The CMO shall:

1. *Written Information*
   Provide written information at time of CMO enrollment to all adults receiving medical care through the CMO regarding:

a. *Members' Rights*
The individual's rights under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and

b. *Policies*
The CMO's written policies respecting the implementation of such rights.

**c. The written information must reflect changes in State law related to advance directives as soon as possible, but no later than 90 days after the effective date of change.**

2. *Documentation*
Document in the member record whether or not the member has executed an advance directive.

3. *Fair Treatment*
The CMO shall not base the provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive. This provision shall not be construed as requiring the provision of care which conflicts with an advance directive.

4. *Education*
Provide education for staff and the community on issues concerning advance directives.

5. *Referral*
Provide referral to appropriate community resources, including the resource center, for any member or individual seeking assistance in the preparation of advance directives.

The above provisions shall not be construed to prohibit the application of any Wisconsin law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider who, as a matter of conscience, cannot implement an advance directive.

**3. Sections I. and J. of Article IV. *Protection of Member Rights* are hereby amended to read as follows:**

I. Fair Hearing Process

1. *Request for Fair Hearing*
A member can file a request for a fair hearing process for the following types of incidences before, during or after using the CMO grievance process:

a. Failure to provide timely services and items that are included in the individual service plan;
b. Reduction of services or items in the LTC benefit package;
c. The Individual Service Plan (ISP) is unacceptable to the member because the ISP requires the member to live in place that is unacceptable to the member;
d. The services or items identified in the ISP are insufficient to meet the member's needs, or are unnecessarily restrictive or unwanted by the member; or,
e. Involuntary disenrollment.

2. *When to File*
The member must file the request for a fair hearing within 45 days of one the types of incidences noted above, or receipt of written notice from the CMO or DHFS (whichever is later).

3. *Timelines*
A decision will be made through the fair hearing process as expeditiously as the member's situation or health condition requires **or within 90 days of the date the member filed a request for the hearing. The decision will be reached within three days of receipt of the hearing request if the standard resolution timeframe could seriously jeopardize the member's life or health or ability attain, maintain, or regain maximum function and,**
   **a. The appeal was first heard by the CMO.**
   **b. The CMO was subject to the expedited appeal process but did not resolve within the expedited timeframe.**
   **c. The appeal involved a denial of service.**
   **d. The CMO decision was wholly or partially adverse to the member using CMO expedited appeal timeframes.**

   Any formal decision made through the fair hearing process under this section, shall be subject to member grievance rights as provided by State and Federal laws and rules. The fair hearing process will include receiving input from the member and the CMO in considering the grievance.

4. *Access to Services*
If the CMO's grievance or appeal resolution decision to deny a service is reversed through the fair hearing process, the CMO shall authorize or provide the service as expeditiously as the member's situation or health condition requires, but no later than 30 days after the receipt of the reversal.

**5. The parties to the appeal include:**
   **a. The member and his or her representative; or**
   **b. The legal representative of a deceased member's estate; and**
   **c. The representatives of the CMO.**

J. Continuation **and Duration** of Benefits

1. *When Services will Continue*
   The CMO shall continue the member's current benefits until the issuance of a**n appeal or** grievance decision under the following circumstances:

   d. The member files a grievance by the date of the intended action, or within 14 days of receipt of the written notice from the CMO and/or DHFS (whichever is later); and
   e. The current level of services was authorized by the CMO interdisciplinary team; and
   f. The member requests the continuation.

***2. Duration***
**If benefits are continued or reinstated, pending the issuance of an appeal or grievance decision, they must be continued until one of the following occurs:**
   **a. The enrollee withdraws the appeal or grievance.**
   **b. The enrollee does not request a State fair hearing within 10 days from when the CMO mails an adverse CMO decision.**
   **c. A State fair hearing decision, adverse to the enrollee is made.**
   **d. The authorization expires or authorization service limits are met.**

~~2~~**3**. *Reasonable Alternatives*
   If the requested services were not authorized by the CMO interdisciplinary team, the CMO shall provide reasonable alternatives to the requested services, as appropriate, until the issuance of the grievance decision.

**4. Section B. of Article V. *CMO Functions: Service Providers* is hereby amended to read as follows:**

B. Provider Network and Subcontracts
The term "subcontract" in this section refers to the definition provided in Addendum I, *Definitions* (page 105). The term does not apply to supplemental contracts between the CMO and DHFS. DHFS shall have sole authority to determine the conditions and terms of supplemental contracts between the CMO and DHFS.

**The CMO may not discriminate for the participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification.**

**If the CMO declines to include an individual or group of providers in its network, it must give the affected providers written notice of the reason for its decision.**

**The CMO provider network selection must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.**

1. *Administrative Costs*
   In establishing provider and management subcontracts, the CMO shall seek to maximize the use of available resources and control costs. **Cost control measures can include:**
   **a. Using different reimbursement amounts for different specialties.**
   **b. Using different reimbursement amounts for different practitioners in the same specialty.**
   **c. Establishing measures that are designed to maintain quality of service consistent with the CMO responsibilities to serve members.**

2. *Subcontractor Audits*
   CMO providers may be eligible for waivers of the audit requirements under s. 46.036(4) Wis. Stats., subject to approval by DHFS.

3. *Department's Discretion*
   DHFS may approve, approve with modification, or deny subcontracts under this contract at its sole discretion. DHFS may, at its sole discretion and without the need to demonstrate cause, impose such conditions or limitations on its approval of a subcontract as it deems appropriate. DHFS may consider such factors as it deems appropriate to protect the interests of the State and members, including but not limited to, the proposed subcontractor's past performance.

4. *Legal Liability*
   The CMO shall assure that all subcontracts shall not terminate legal liability of the CMO under this contract. The CMO may subcontract for any or all functions covered by this contract, subject to the requirements of this contract.

5. *Deadlines*
   If DHFS requires the CMO to find a new subcontractor, the CMO shall secure a new subcontractor in 120 calendar days, and 60 calendar days to implement any other change required by DHFS. DHFS will acknowledge the approval or disapproval of a subcontract within 14 calendar days after its receipt from the CMO. Lack of such acknowledgment within 14 calendar days shall constitute approval.

6. *Member Provider Communications*
   The CMO may not prohibit or otherwise restrict a provider from advising members about the long-term care and health care status of the member, or medical care and treatment for the member's condition or disease regardless of whether the service are services in or outside of the LTC benefit package if the provider is acting under the lawful scope of practice.

7. *Evidence of Service Capacity Before Effective Date of Contract*
   By the effective date of this contract, the CMO shall have submitted its subcontracts or revisions to subcontracts previously approved, and obtained Department approval by one of two means: 1) the CMO submits each subcontract to DHFS for review and approval or disapproval, or 2) the CMO submits template language to DHFS planned for use in the CMO's subcontracts for Department review and approval or disapproval. After the CMO receives approval on templates, the CMO sends DHFS a certification stating the approved templates were used for each subcontractor. For each subcontractor the certification includes the subcontractor's name, service type and date of subcontract expiration. Any disapproval of subcontracts may result in the application by DHFS of remedies pursuant to Article VIII.L, *Remedies for Violation, Breach or Non-Performance of Contract* (page 86).

   By the effective date of this contract, the CMO shall demonstrate to DHFS an adequate capacity to provide the projected membership in the service area with: the appropriate range of services; access to prevention and wellness services; a sufficient number, mix and geographic distribution of providers of services; specialized expertise with the target population(s) served by the CMO; culturally competent providers (see F. *Cultural Competency*, page 62); and services that are physically accessible and available on a timely basis. Any CMO that will, at any time during the term of this contract, operate the CMO in a service area where the Family Care benefit has been available for at least 24 months, shall demonstrate capacity to provide services to all entitled persons who seek enrollment in the CMO. **The CMO is not required to contract with providers beyond the number necessary to meet the needs of the members.**

   The CMO shall develop standards for geographic access and timeliness of access to services in the LTC benefit package and member services that meet or exceed such standards as may be established by CMS or DHFS.

   Evidence of adequate capacity to serve the membership is as follows:
   a. For all services in the LTC benefit package evidence of adequate capacity to serve the membership is by subcontractual relationships with providers or ability to provide the service directly.
   b. For residential care facilities evidence of adequate capacity shall include identification of the availability of residential providers offering private

rooms, and a process for moving an individual to a private room when one becomes available that is consistent with the member's preferences.

8. *Evidence of Service Capacity After Effective Date of Contract*
   DHFS may review any and all subcontracts at any time.

   a. *Certification of Subcontracts*
      An certification of subcontracts shall be submitted and receive Department approval before renewing this contract, and at any time DHFS determines there has been a significant change in the CMO's capacity to offer services in the LTC benefit package or in the CMO's projected membership. The certification shall include:
      i. A statement that all of the required provisions of subcontracts are met (see 9. *Requirements for Subcontracts* below);
      ii. A listing of the provider network (which consists of provider/agency name, location, services furnished by provider, and whether the provider is accepting new CMO members or not); and,
      iii. Expiration date of all subcontracts.

   b. *Notices About Provider Changes*
      Notices about changes in providers that are to be sent to members must be submitted to DHFS for approval and will be approved as soon as possible, but within 30 calendar days. **Upon approval, the CMO shall provide each member written notice of the change at least 30 days before the effective date of the change.**

   c. *Information to Members*
      Upon the request of members, the CMO shall make available information about the identity, locations, qualifications, and availability of services in the LTC benefit package from providers that participate in the CMO.

   d. *Timeliness and Quality of Services*
      The CMO shall furnish services in the LTC benefit package promptly and without compromising quality of care.

   e. *Monitoring Access to Services*
      The CMO shall continuously monitor the extent to which it maintains an adequate capacity to provide the membership with the appropriate range of services, access to prevention and wellness services, a sufficient number, mix and geographic distribution of subcontractors of services, specialized expertise with the target population(s) served by the CMO before the effective date of the contract, culturally competent providers, (see F, *Cultural Competency*, page 62), and accessible services (meaning physically accessible, and available on a timely basis). The CMO shall take corrective action on deficiencies in any of these areas as necessary.

9. *Requirements for Subcontracts*
   All subcontracts shall be in writing, shall include the provisions of this subsection, and shall include any general requirements of this contract that are appropriate to the service. The subcontractor must agree to abide by all applicable provisions of this contract. Subcontractor compliance with this contract specifically includes, but is not limited to, the following requirements (except for specific areas that are inapplicable in a specific subcontract):

   a. *Parties of the Subcontract*
      The CMO and subcontractor entering into the agreement are clearly defined.

   b. *Definitions*
      Subcontract defines the terms that may be interpreted in ways other than what the CMO intends.

   c. *Services*
      Subcontract clearly delineates the services being provided, arranged, or coordinated by the subcontractor.

   d. *Compensation*
      Subcontract specifies rates for purchasing services from the provider. Subcontract specifies payment arrangements in accordance with Article V.C(3), *Thirty-Day Payment Requirement* (page 58).

   e. *Term and Termination*
      Subcontract specifies the start and end date of the subcontract and the means to renew, terminate and renegotiate. Subcontract specifies the CMO's ability to terminate and suspend the subcontract based on quality deficiencies and a process for the provider appealing the termination or suspension decision.

   f. *Legal Liability*
      Subcontract agrees that no terms of the subcontract are valid which terminate legal liability of the CMO in accordance with Article VII.F, *Compliance with Applicable Law* (page 80).

   g. *QA/QI Programs*
      Subcontractor agrees to participate in and contribute required data to the CMO's QA/QI programs as required in Article VI, *CMO Functions: Quality Assurance/Quality Improvement*, (page 63).

   h. *Utilization Data*
      Subcontractor agrees to submit CMO utilization data in the format specified by the CMO, so the CMO can meet DHFS specifications

required by Article X, *Reports and Data* (page 92), and Addendum IV, *Reporting* (page 127).

i. *Non-Discrimination*
Subcontractor agrees to comply with all non-discrimination requirements in Article VII.D, *Civil Rights* (page 77).

j. *Insurance and Indemnification*
Subcontractor attests to carrying the appropriate insurance and indemnification.

k. *Independent Contractor*
Subcontract recognizes the agreement is between two separate parties that are independently and freely entering into a subcontract.

l. *Notices*
Subcontract specifies a means and a contact person for each party for purposes related to the subcontract (e.g. interpretations, subcontract termination).

m. *Access to Premises*
Subcontractor agrees to provide representatives of the CMO, as well as duly authorized agents or representatives of DHFS and the Federal Department of Health and Human Services, access to its premises, and/or medical records in accordance with Article VII.I, *Access to Premises and Information* (page 82).

n. *Certification and Licensure*
CMO subcontractors and health care facilities agree to provide licensure, certification and accreditation status upon request of the CMO. Health professions which are certified by Medicaid (e.g. physical therapy) agree to provide information about their education, Board certification and recertification upon request of the CMO. Subcontractor agrees to notify the CMO of changes in licensure.

o. *Records*
Subcontractor agrees to comply with all applicable Federal and State record retention requirements.

p. *Member Records*
Subcontractor agrees to the requirements for maintenance and transfer of records stipulated in Article VII.B, *Member Records* (page 74). Subcontractor agrees to make records available to members and his/her authorized representatives within ten business days of the record request.

Subcontractors must forward records to the CMO pursuant to grievances within 15 business days of the CMO's request. If the subcontractor does not meet the 15-business day requirement, the subcontractor must explain why and indicate when the records will be provided.

Subcontractor agrees otherwise to preserve the full confidentiality of records in accordance with Article XIII, *Confidentiality of Records* (page 101).

q. *OSHA Requirement*
Subcontractor attests to meeting applicable OSHA requirements.

r. *Access to Services*
Subcontractor agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of services necessary to achieve outcomes that are in the LTC benefit package (e.g., Third Party Liability recovery procedures that delay or prevent care).

s. *Authorization for Providing Services*
Subcontract delineates the process the provider follows to receive authorization for providing services in the LTC benefit package to members. Subcontractor agrees to clearly specify authorization requirements to its providers and in any sub-subcontracts.

t. *Billing*
Subcontractor agrees not to bill a member for services in the LTC benefit package that received advance authorization from the CMO and were provided during the member's period of CMO enrollment. This provision shall continue to be in effect even if the CMO becomes insolvent.

u. *Appeals*
Subcontractor agrees to abide by the terms of Article V.C(5), *Appeals to the CMO and Department for Payment/Denial of Providers Claims* (page 58).

v. *Appeals and Grievances*
Subcontractor agrees to comply with the CMO's efforts regarding member's appeals and grievances that may involve the subcontractor.

**w. The CMO and subcontractor agree to prohibit communication, activities or written materials that make any assertion or statement, that the CMO or provider is endorsed by CMS, the Federal or State government, or any other entity.**

*10. In establishing and maintaining subcontracts, the CMO must:*

a. Establish mechanisms to ensure compliance by providers.
b. Monitor providers regularly to determine compliance.
c. Take corrective action if there is a failure to comply.

11. *Additional Requirements for Management Subcontracts*
Management subcontracts for administrative services will be subject to additional review to assure that rates are reasonable:

a. *Services and Compensation*
Subcontracts for CMO administrative services must clearly describe the services to be provided and the compensation to be paid.

b. *Bonuses, Profit-Sharing*
Any potential bonus, profit-sharing, or other compensation not directly related to costs of providing goods and services to the CMO, shall be identified and clearly defined in terms of potential magnitude and expected magnitude during the subcontract period.

c. *Reasonableness*
Any such bonus or profit-sharing shall be reasonable compared to services performed. The CMO shall document reasonableness.

d. *Limits*
A maximum dollar amount for such bonus or profit-sharing shall be specified for the subcontract period.

12. *Ownership*
The CMO agrees to submit to DHFS within 30 calendar days of the effective data of the contract, full and complete information as to the identity of each person or corporation with an ownership or control interest in the CMO, or any subcontractor in which the CMO has a 5% or more ownership interest.

a. *Definition of "Person with an Ownership or Control Interest."*
A "person with an ownership or control interest" means a person or corporation that:
i. Owns, directly or indirectly, 5% or more of the CMO's capital or stock or receives 5% or more of its profits. The percentage of direct ownership or control is calculated by multiplying the percent of interest which a person owns by the percent of the CMO's assets used to secure the obligation. Thus, if a person owns 10% of a note secured by 60% of the CMO's assets, the person owns 6% of the CMO. The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization. Thus, if a person owns 10% of the stock in a corporation which owns 80% of the stock of the CMO, the person owns 8% of the CMO.

ii. Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the CMO or by its property or assets, and that interest is equal to or exceeds 5% of the total property and assets of the CMO; or,
iii. Is an officer or director of the CMO (if it is organized as a corporation) or is a partner in the CMO (if it is organized as a partnership).

b. *Information to be Disclosed*
The following information must be disclosed:
i. The name and address of each person with an ownership or controlling interest of 5% or more in the CMO or in any subcontractor in which the CMO has direct or indirect ownership of 5% or more;
ii. A statement as to whether any of the persons with ownership or control interest are related to any other of the persons with ownership or control interest as spouse, parent, child, or sibling; and,
iii. The name of any other organization in which the person also has ownership or control interest. This is required to the extent that the CMO can obtain this information by requesting it in writing. The CMO shall keep copies of all of these requests and responses to them, make them available upon request, and advise DHFS when there is no response to a request.

c. *Potential Sources of Disclosure Information*
This information may already have been reported on Form HCFA-855, "Disclosure of Ownership and Control Interest Statement." Form HCFA-855 is likely to have been completed in two different cases. First, if the CMO is Federally qualified and has a Medicare contract, it is required to file Form HCFA-855 with CMS within 120 calendar days of the CMO's fiscal year end. Secondly, if the CMO is owned by or has subcontracts with Medicaid providers which are reviewed by the State survey agency, these providers may have completed Form HCFA-855 as part of the survey process. If Form HCFA-855 has not been completed, the CMO may supply the ownership and control information on a separate report or submit reports filed with the State's insurance or health regulators as long as these reports provide the necessary information for the prior 12-month period.

As directed by the CMS Regional Office (RO), this Department must provide documentation of this disclosure information as part of the prior approval process for contracts. This documentation must be submitted to DHFS and the RO prior to each contract period. If the CMO has not supplied the information that must be disclosed, a contract with the CMO is not considered approvable for this period of time and no full Federal participation is available for the period of time preceding the disclosure.

d. *Prohibited Providers*
The CMO may not knowingly have a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities as a director, officer, partners, or person with a beneficial ownership of more than 5% of the entity's equity, or have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the CMO's obligations under this contract.

13. *Business Transactions*
The CMO shall disclose to DHFS information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act. (See Sections 1903(m)(2)(A)(viii) and 1903(m)(4) of the Act.) Definition of a Party in Interest. As defined in Section 1318(b) of the Public Health Service Act, a party in interest is:
a. Any director, officer, partner, or employee responsible for management or administration of a CMO; any person who is directly or indirectly the beneficial owner of more than 5% of the equity of the CMO; any person who is the beneficial owner of more than 5% of the CMO; or, in the case of a CMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law; or
b. Any organization in which a person described in subsection (a) is director, officer or partner; has directly or indirectly a beneficial interest of more than 5% of the equity of the CMO; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the CMO;
c. Any person directly or indirectly controlling, controlled by, or under common control with the CMO; or
d. Any spouse, child, or parent of an individual described directly above in a, b or c.

14. *Types of Transactions Which Must Be Disclosed*
Business transactions which must be disclosed include:

a. Any sale, exchange or lease of any property between the CMO and a party in interest;
b. Any lending of money or other extension of credit between the CMO and a party in interest; and,
c. Any furnishing for consideration of goods, services (including management services) or facilities between the CMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of his/her employment.

The information which must be disclosed in the transactions listed directly above between the CMO and a party in interest includes:
i. The name of the party in interest for each transaction;

ii. A description of each transaction and the quantity or units involved;
iii. The accrued dollar value of each transaction during the fiscal year; and,
iv. Justification of the reasonableness of each transaction.

If this contract is being renewed or extended, the CMO shall disclose information on these business transactions which occurred during the prior contract period. If the contract is an original contract with DHFS, but the CMO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving the Medicaid enrollment. All of these CMO business transactions must be reported.

The CMO shall notify DHFS within seven calendar days of any notice given by the CMO to a subcontractor, or any notice given to the CMO from a subcontractor, of a subcontract termination, a pending subcontract termination, or a pending modification in subcontract terms, that could reduce member access to care.

If DHFS determines that a pending subcontract termination or pending modification in subcontract terms will jeopardize member access to care, then DHFS may invoke the remedies provided for in Article VIII.L, *Remedies for Violation, Breach, or Non-Performance of Contract* (page 86). These remedies include contract termination (with notice to the CMO and an opportunity to correct provided for), and suspension of new enrollment.

The CMO shall submit MOUs referred to in this contract to DHFS upon DHFS's request.

The CMO shall submit copies of changes in MOUs to DHFS within 15 calendar days of the effective date of the contract.

**5. Section F. of Article VII. *CMO Functions: Administration* is hereby amended to read as follows:**

F. Compliance with Applicable Law
The CMO shall observe and comply with all Federal and State law in effect when this contract is signed or which may come into effect during the term of this contract, which in any manner affects the CMO's performance under this contract, except as specified in Article III.A, *Provision of Service in the LTC Benefit Package* (page 14)**, including the Byrd Anti-Lobbying Amendment**.

6. **Section M. is hereby added to Article VIII. *Functions and Duties of DHFS* to read as follows:**

   **M. Conflict of Interest**
   **DHFS maintains that department employees are subject to safeguards to prevent conflict of interest as set forth in Section 19 of Wisconsin Statutes.**

7. **Section A. of Article IX. *Payment to CMO* is hereby amended to read as follows:**

   A. Per Member Per Month Payment Rates
   In full consideration of services in the LTC benefit package rendered by the CMO, DHFS agrees to pay the CMO monthly payments based on the per member per month payment rate specified in Addendum VI, *Actuarial Basis* (page 132). ~~The per member per month payment rate shall be prospectively designed to be less than the cost of providing the same services covered under this contract to a comparable Medicaid population on a fee-for-service basis.~~ The per member per month payment rate shall not include any amount for recoupment of losses incurred by the CMO under previous contracts.

8. All terms and conditions of the contract and addendums, and any prior amendments that are not affected by this amendment, shall remain in full force and effect through the duration of the contract, and the terms of this amendment shall be fully incorporated into the contract by this reference and fully enforceable as any other term.

9. This amendment takes effect as if it were a part of the Health and Community Supports Contract between DHFS and CMO entered into on January 1, 2003, when executed by both parties indicated below.

In WITNESS WHEREOF, the State of Wisconsin and (County) County have executed this contract:

| FOR CMO: | FOR STATE: |
|---|---|
| BY: (Signature)<br>(Title) | BY: Sinikka Santala, Administrator<br>Division of Disability and Elder Services |
| DATE: | DATE: |